

Healthcare Transformation Concepts and Definitions

Our healthcare transformation process is invigorated by many stakeholders with differing backgrounds. To help them with new terms and all of us to use the same terms in the same way, here is a brief overview of the concepts, definitions, and acronyms we'll be using.

Delivery System Innovation

Problem: We have a fragmented system in which providers frequently don't talk with each other. This results in costly duplication of services, errors caused by lack of information, and confusion for patients. Moreover, the system doesn't typically engage the patient and his/her family to ensure an understanding of the health problem and active partnership in improving health. Our island geography also contributes to too few providers and other resources being available in rural places or to people with economic and cultural barriers to care.

Solutions:

1. Make our healthcare system behave like a system
2. Put patient needs and engagement at the center of the care structure
3. Overcome resource maldistribution and geographic barriers

Proposed priority strategies:

1. Patient-centered medical homes
2. Community care teams
3. ACO-like structures ("Island Accountable Organizations", or IAO)

Here's why we think the proposed strategies address the problem and meet the stated goals.

Patient-Centered Medical (or Health Care) Home (PCMH)

A variety of providers, payers, and accreditation agencies have somewhat differing definitions of patient-centered care. To us, the characteristics of a PCMH include the following:

1. The "home" is an on-going source of primary health care where the provider is familiar with the patient's needs, circumstances, and normal condition. The patient's regularly visits to the same provider promotes early detection of new problems and facilitates preventive care.
2. Services are provided by a team with the physician collaborating with other professional and paraprofessional team members who can most effectively address the needs of the patient. The team might include a nurse practitioner or physician assistant, RN, dietician, clinical pharmacist, social worker, community health worker, or others, depending on the nature of the practice.
3. The emphasis is on the patient and his/her family or support system. This emphasis includes patient engagement, which means ensuring that the patient understands his/her health status, what options are available to address any problems, is an active partner in deciding which of the options is most acceptable, and works with the provider team for a successful outcome. Patient engagement is also proactive in identifying patient health risks and working with the patient and his/her family to reduce or avoid them.
4. Increased access is also a key part of the PCMH. PCMH patients are able to contact their provider by phone or internet outside of office appointments. They can get advice and/or an appointment for new problems promptly, which helps them avoid inappropriate trips to emergency rooms.
5. The "home" maintains the patient's medical records, including information from referral visits and services, hospitalizations, and all diagnostic services and prescriptions.
6. A PCMH uses health information technology effectively.
 - a. Electronic health records (EHRs). The PCMH keeps records electronically, which helps reduce errors and is essential for timely information exchange.
 - b. Health information exchange (HIE). The PCMH exchanges vital health information electronically to ensure records are always complete and up to date and are available to other providers who are also caring for the patient (e.g., a specialist or a hospital).

- c. Registries. Registries are databases populated by information about patients with chronic diseases or other special needs. Registries help the provider team identify which patients are doing well and which may need additional outreach and assistance.
 - d. Sharing among team members. Because the PCMH is a team approach, team members need appropriate, timely information about the patient and status of care to contribute effectively to supporting the patients' wellbeing.
7. Manages referrals. The PCMH actively supports referrals for services the patient needs from other providers (e.g., dental care, behavioral health services, medical specialists) to help patients get appointments, comply with any follow-up instructions, and get all the records back to the "home" master file.

Community Care Teams (CCTs)

A complete PCMH would have team members who enhance successful communication between providers and patients, making sure that patients make and keep appointments with all their care providers, get their labs and prescriptions, understand how to take their medications, reach out to ensure patients get preventive care, and otherwise ensure that the patient/family members successfully navigate the health care system. In real life many primary care physicians, especially solo or small practices, cannot support such a comprehensive structure. Community care teams fill the breach. The physician doesn't have to employ the community care workers – a separate agency or their independent physicians association (IPA) could do that.

In some models, only patients with specific chronic health risks would be entitled to CCT services and these services would be paid by Medicaid or a health plan. In others, all patients are entitled to the benefits of the CCT if needed and the CCT services are provided by separate nonprofit organizations which are paid by funds contributed by all insurers.

Accountable Care Organizations (ACO) Like Structures.

Primary care is really important but it isn't the only service patients need over the course of a lifetime. The ACO incorporates the virtues of PCMH and CCT models as it goes to the next level, which is successful coordination across the whole continuum of care. An ACO proposes that a network of providers (primary care, specialty, and hospital) collaborate to provide the entire spectrum of care for a group of patients. It is also a payment strategy in that the provider network gets a single fee for each patient and all providers have financial incentives to cooperate in providing the best and most cost-effective care for the patient. The providers must meet quality targets and focus on primary care and prevention to encourage good health and lower costs for their patients. This coordination and interdependence requires seamless information sharing and attention to performance and cost data.

We are terming this "ACO-like" because the Centers for Medicare and Medicaid Services (CMS) created a specific structure and a demonstration project for Medicare patients which is more prescriptive and narrowly focused than we'd expect our model to be. We are suggesting we use "Island-Accountable Organizations" (IAO) to develop a locally-appropriate model that coordinates care across the spectrum of patient needs in rational geographic areas.

Payment Innovation

Problem: In our typical payment system nobody gets paid if the patient isn't sick. The greatest rewards are for the most specialized services and payments are triggered only by visits to providers and procedures that are done. This system pays less for primary care, little for prevention, and usually nothing for care management or communication among providers or patients. There is no reward for working with patients and their families as partners in better health.

Solutions:

1. Change the payment system so it supports the kind of delivery system we want.
2. Reward the right patient and provider behavior.

Proposed priority strategies:

1. Pay for performance and value based purchasing
2. Shared savings models
3. Bundling payments

Here's why we think the proposed strategies address the problem and meet the stated goals.

Pay for Performance (P4P) and Value Based Purchasing

Providers in a pay for performance model are rewarded for meeting certain pre-established quality measures in delivering health care. This concept requires agreement, or harmonization, of measures for all providers with active public health and health plan input to identify the diseases and metrics to be prioritized. P4P depends on provider use of electronic health records and patient registries and is related to the establishment of clinical and claims databases.

The next step in using P4P measurement is value based purchasing where payers (employers or systems like EUTF, for example) steer their enrollees toward care givers with the best records for both quality and cost-effectiveness sometimes by reducing the amount the enrollee pays if they use the preferred services. This requires clinical and claims databases and public reporting of performance.

The federal Agency for Healthcare Research and Quality (AHRQ) says this about value-based purchasing:

The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved.

The key elements of value-based purchasing include:

- **Contracts** spelling out the responsibilities of employers as purchasers with selected insurance, managed care, and hospital and physician groups as suppliers.
- **Information** to support the management of purchasing activities.
- **Quality management** to drive continuous improvements in the process of health care purchasing and in the delivery of health care services.
- **Incentives** to encourage and reward desired practices by providers and consumers.
- **Education** to help employees become better health care consumers.

Shared Savings Models

In the shared savings concept, health plans share the savings with providers if they reduce expected costs while maintaining or improving quality. This payment structure can be applied to incentivize the use of patient-centered medical homes, community care teams, or accountable care organizations. Shared savings models would most effectively be used where data indicate excessive utilization of high cost services, particularly those that might be

amenable to reduction via better management. Such services might target reduction of emergency room use or identifying and intervening in the care of the top 5% of a health plan's utilizers.

Bundling Payments

In this concept a single payment based on expected costs would be made available to hospital-based specialists, facility, and post-discharge providers involved in delivering care for a discrete medical episode such as heart bypass surgery or hip replacement. Bundling payments is a strategy intended to increase coordination and communication among providers and reduce unnecessary care that sometimes results in the fee for service model. The model also reduces the pitfalls of a strictly capitated system that could punish providers who care for sicker patients. Effective long-term use of this model requires additional clinical and cost data to ensure fair and appropriate levels of payment to support both quality and value.

Transformative Health Information Technology

Problem: Effective delivery system innovations and the payment models needed to support them require the availability and use of clinical and cost-related information across the continuum of care and for the benefit of the consumers, payers, and public health.

Solutions:

1. Ensure electronic health records support treatment where and when needed.
2. Share timely information with appropriate stakeholders.
3. Use data to identify and address areas for clinical improvement and cost saving.

Proposed priority strategies:

1. EHRs and HIE for meaningful use
2. Clinical and claims repository
3. Timely reporting and feedback

Here's why we think the proposed strategies address the problem and meet the stated goals.

EHRs and HIE for Meaningful Use

"Meaningful Use" is a term used by the HITECH Act in the American Recovery and Reinvestment Act (ARRA) for a set of expectations related to improving care and communication via electronic health records (EHRs) and appropriate health information exchange (HIE).

Use of electronic health records (EHRs) is the foundation, providing a means to maintain legible and complete records (including clinical, demographic, and health risk information), reduce errors via built-in decision support that flags possible inconsistencies in the record, and for managing the health of a specific subset of patients with elevated care needs or risks (this is a "registry" function).

Meaningful use requires the next step, which is to share information via a secure health information exchange to prescribe medications and receive laboratory results; report clinical and demographic information; meet public health surveillance and other requirements; and, of course, to share appropriate and timely patient information with the patients themselves, with members of the care team in a PCMH, and with other providers involved in a patient's care.

Clinical and Claims Repository

Together EHRs and HIE are necessary to support the development of clinical and claims repositories where key information can be collected, analyzed, and reported. A data repository that links clinical and claims information is crucial to supporting both the delivery system and payment strategies identified above by:

- Identifying performance on quality measures, establishing benchmarks, and encouraging comparisons for providers.

- Identifying cost outliers and informing strategies for improvement.
- Providing public information about the health care system.
- Supporting public health functions such as epidemiology, disease surveillance and reporting, and chronic care management.
- Adding to evidence-based practice for good outcomes and cost-effectiveness.
- Increasing our capacity for anticipatory treatment to identify and provide preventive care for at risk patients.

Timely Reporting and Feedback

Considering the importance and complexity of healthcare there is little done to establish common clinical standards and ensure that clinicians use them to measure and/or report their performance. A variety of innovators have demonstrated the value of establishing measure and providing feedback on them to allow providers to compare their own outcomes with that of their peers. Developing a system of timely feedback to patients is also essential to support their own efforts toward meeting their goals for health improvement.

EHRs, HIE, and data repositories are tools to gather, analyze, and share the information we need to continually improve our health care system.

Policy & Purchasing

Problem: The healthcare system is large and complex. It needs a powerful catalyst to help it move in the right direction. The State can be that catalyst because it insures 1/3rd of the residents of Hawaii, spends billions of dollars for that coverage, and has policy-making authority that can be mobilized for further transformation. The historic context for Medicaid, EUTF, and public health has separated these programs; joined together they are a significant force for healthcare innovation in Hawaii and can lead in the continuous evolution of improvement.

Solutions:

1. Ensure that state government policy is consistently applied for public health and all insurance and services purchased by the state.

Proposed priority strategies:

1. Alignment in state government for health policy and purchasing
2. Capacity for on-going healthcare innovation

Here's why we think the proposed strategies address the problem and meet the stated goals.

Alignment in State Government for Health Policy and Purchasing

Our innovation strategies include embracing models of care not yet commonly used here, supporting them with different payment modes, and using health information technology as the foundation for both. We need to adopt these priorities as crucial state health policies and ensure that they become central to purchasing strategies for MedQUEST and EUTF.

Capacity for On-Going Healthcare Innovation

Healthcare transformation will be a continuous process new data, models, technologies, and workforce solutions are developed. Hawaii needs a permanent investment and structure to support healthcare research and innovation in the public interest with the authority to strongly influence policy and purchasing.

Acronyms & Definitions

Healthcare has many acronyms and arcane uses or language that insiders throw around. Here are some of the ones we expect to toss:

AAPI. Asian Americans and Pacific Islanders.

ACA. The Affordable Care Act, aka, the Patient Protection and Affordable Care Act (PPACA).

ACO. Accountable care organization.

CAD. Coronary Artery Disease.

CMS. Centers for Medicare and Medicaid Services in the federal Department of Health and Human Services, which promulgates policy and funds the largest health coverage programs in the United States.

CCN. Community care network or community care team.

CCT. Community care team or community care network.

CHF. Congestive heart failure.

DM. Diabetes mellitus.

EHR. Electronic health record.

EHR Incentive Program. CMS has a program of financial incentives for Medicaid and Medicare hospitals and providers who implement EHRs for meaningful use.

EUTF. Hawaii Employer-Union Trust Fund. The Hawaii Employer-Union Health Benefits Trust Fund is really what we're discussing in this initiative.

Health Neighborhood. If a patient-centered medical home is the construct for primary care for a patient the concept of "health neighborhood" implies communication and good care management across the whole continuum of care.

HIE/HHIE. Health information exchange. HHIE is the nonprofit, statewide Hawaii Health Information Exchange which develops the system for exchange across providers and also serves as the regional extension center (REC) to help physicians implement their EHRs.

HTN. Hypertension.

IAO. We're suggesting creating the "Island-Accountable Organization" in place of the ACO model.

IHI. Institute for Healthcare Improvement, a private organization that has been highly influential in healthcare transformation thought over the past several decades.

IPA. Independent Physician Association, organizations that support physicians' business and practice needs.

Measure Harmonization. There are numerous possible clinical outcomes and specific metrics. "Harmonization" means we agree on a relatively small number of greatest significance and standardize the methodologies for metrics and reporting.

Medicaid. The program that provides coverage for low-income individuals and families, including elderly and disabled people. The federal and state government share the cost but CMS maintains policy discretion.

Medicare. The program that provides coverage for the elderly and people with chronic disabilities.

MPCD. Multi-payer claims database. Sometimes all payer claims database or APCD.

MU. Meaningful use (of electronic health records and health information exchange).

ONC. Office of the National Coordinator for Health Information Technology in the federal Department of Health and Human Services.

P4P. Pay for performance.

PCMH. Patient-centered medical home or, often, patient-centered health care home (PCHCH) which implies a broader view of healthcare than medical services.

PCP. Primary care provider.

PMPM. Per member per month, usually used in discussing capitated payments to providers.

Social Determinants of Health. Low income people are typically at higher risk for poor health not just because they may struggle to get access to timely health care but because they are also more likely to live in places with more pollution and crime, few opportunities for physical recreation, less healthy and affordable food, and inferior educational opportunities. They are also more likely to be minorities who live with the on-going stress of discrimination.

Triple Aim. The IHI and, subsequently, the federal government has adopted this as the criteria for innovation: Better health, higher quality, and increased value.